PRINTED: 06/19/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLÍA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 05/30/2008 B. WING 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, NE NAME OF PROVIDER OR SUPPLIER WASHINGTON, DC 20019 INNOVATIVE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) PRÉFIX TAG 7/4/08 W 000 INITIAL COMMENTS W 000 This recertification survey was conducted from May 28, 2008 to May 30 2008. The survey was initiated as a fundamental survey. As a result of identified deficiencies in the area of active treatment a decision was made to conduct a full survev. At the time of the survey four females and two males clients resided in this group home. One female was diagnosed with moderate mental retardation, and the remaining clients were diagnosed with mild mental retardation. These clients had multiple medical diagnoses. During this survey, five clients were present as one female had been hospitalized prior to the survey. One male client remained in the group home during the day and was periodically repositioned from his bed to his wheelchair. The five clients that were observed had physical challenges and required assistance to ambulate or mobilize within their environment. A random sampling of three clients was selected for the purposes of this survey. Findings of the survey were based on interviews with clients, direct care staff, and medical staff. The findings were also based on observations at the group home and day program settings, and review of records, including incident reports and investigations. At the conclusion of the survey, the facility was found out of compliance with the federal requirements of Active Treatment, and Facility 7/4/08 Staffing. 440 150(c) TCF SERVICES OTHER THAN IN W 100 W 100 INSTITUTIONS (X6) DATE OR'S OR PROVIDED SUPPLIER REPRESENTATIVE'S SIGNATURE

ABORATORY DIR renie Any deficiency statement ending with an asterisk (\*) devotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date of survey whether or not a plan of correction is provided. days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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<u> </u>			W 1.00.			\
W 100	services in an inst	age 1 facility services" may include tution for the mentally retarded to as intermediate care is with mental retardation) or				
	persons with relat	ed conditions if: urpose of the institution is to rehabilitative services for individuals or persons with				
	related conditions (2) The institution E of Part 442 of the	meets the standards in Subpart his Chapter, and etarded recipient for whom	re.			
	havment is reque	sted is receiving active cified in §483.440.				
	Based on observ	is not met as evidenced by ations, interviews, and review of ity failed to ensure that each seded active treatment services.				
W 104	4 483.410(a)(1) G	OVERNING BODY	W 104			,
	The governing b budget, and ope	ody must exercise general polic rating direction over the facility.	<b>y</b> .,			
	This STANDAR	D is not met as evidenced by				
	Based on obser record review the formula as evident	vations, staff interviews and the le facility's governing body failed ral operating directions over the need by the following and the led throughout this report:	17.	The governing body will adequate operating direct implementing a new on-	nons by	7/4/08
	deficiencies cite			tools and protocols.		
		Exent ID: 70	OV11	Facility ID: 09G194	If continuation she	et Page 2 of

		& MEDICAID SERVICES	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE SUI	RVEY
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI			, COIVII EZ I	7
ANDIDANO	- 4					05/20	/2008
		09G194	B. WIN				72008
<u> </u>				STREET	ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF P	ROVIDER OR SUPPLIER		•	1:14 DI	IVISION AVENUE, NE		
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	<u></u>		10/	404		. [	7/4/08
 W 104	Continued From P	age 2	\	104		1	
	Daving the entire	sirryev period, client#3	1:	Al	though client #3 had be	en released to	} {
	i an ad of his fa	cility throughout the day.		1	to the day program		1
	Associate to the	DN MUO MSS TITLET VIEWED ON		10.	aaa Manager are WOIKII	டு பூப்பட்டி	
	Transport 2008 (3.7	(U. DIM) Client #3 Had Hor			lequate day program to	meet client	,
		de day program in over one		ac	requate day program to	eeds	
	Departedly	Client #3 Was off Dedicar to		+ \#3	3's medical and social r	India.	
		adiot a stirotcal would on the					.∤
	L - L Accordin	id to the clients interior	' <u>'</u> .'		· ·		
	he was released	by the wound care center in					
	February 2008 at	nd his primary care physician					
	permitted the clie	ent to return to a day program or	<b>'</b>  .	~			
la l	March 11, 2008						
		2008 at				a-le with DDS t	0
	Client #3 was int	erviewed on May 30, 2008 at			ILS will continue to we	OIK WITH DOD'	7/4/08
	1:40 PM regardii	ng his interest in going to an			provide client #3 appro	priate day	
	autoido placeme	nt The Client Was in agreement			placement. ILS continu	ies to provide i	n-
	to attending and	stated some factors that he	1		home day services.		
	would like for the	e facility to provide at the			nome day sex (2000)		1
	placement			y	<i>#</i> .		
		Professional			and the second of the second o		
1	The Qualified M	ental Retardation Professional	∃e	ŀ			
1	was interviewed	on May 30, 2008 at 3:30 PM. I		1			
.,	indicated that he	e was awaiting the referral				T.	
	generated by th	e casemangager. He indicated		1			
	that a referral h	Se heelt war.				_	<sup>1</sup> 7/4/08
		nis survey, there was no			The referral from DDS	s was made,	L-p
(1) - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	At the time of the	ridence of a referral to a placem	ent		1 II S is not pr	ovided a copy of	of
	documented ev	cility placement for client #3 had	i l		the referral as it is ser	t to the Day	
	been identified	City piacos				r S will request	ta
	Deen ideriiined	SERVICES PROVIDED WITH		W 120	Treatment Program.	Lo Win require	
W 1	20 483.410(d)(3) OUTSIDE SOU	TRCES			copy from the DDS C	ase manager.	
	TEL ENGINE	st assure that outside services					
	meet the need	s of each client					
	Theer meniced						
						•	
	This STANDA	RD is not met as evidenced by		* * *			
	Based on obse	ervation, interviews with the clie	nt	•			
1					nellhetD: 09G194	If continuation	sheet Page 3 c

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	ari) MI	וו דום	LE CONSTRUCTION	-	(X3) DATE SUF	RVEY
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		TO DEFICIENCIES	 ID:		PROVIDER'S PLAN O (EACH CORRECTIVE AC		JULU UL	(X5) COMPLETION
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TAG			-		A STATE OF THE STA			
1 220,400	Continued From p	age 3	W	120	7.			
W 120		ard review the facility falled to						-
	and start, and rec	e contracted services met the	·					7/4/00
	needs of client #2	in the sample			ILS will meet with the	Day P	rogram	7/4/08
	Heeds of offerna					237734	111141	
	The finding includ			- N	opportunities. ILS wil	ensur	e client #2's	s  ·   †
	こうじゅうしゅうしゅぶん こうしんまく デヤス ディス・ムコ しょうしゃ	그리에는 그림에서 백문학생님은 아니는 이 끝나는 그는 네트를 가지 않는데 다른데 없다.			vocational skills are re	-assess	sed,	
	Client#2's day pr	ogram failed to provide the client			4 Lagad on the	· assess	meni	
	All managements	al Annorminines as outlined in the	1		provided by the Physi	cal The	erapist there	
	assessments. A	so, the day program failed to equipment options that would	1		has been a considerab	le decl	ine in client	
	explore adaptive	er independent and possible job			has been a considerate	oc and	those items	
-	provide ner rurur	nced by the following:			#2's functional ability	.es and 1-1-m	uld no	
	<ul><li>(1) 別に合き、 アニューを集まれる。 関う。</li></ul>				originally recommen	ded wo	and HO	
	1 Client #2 has	been diagnosed with severe			longer be appropriate	tor cu	ent #2.	
	1	NATION DATED THE THEOLOGICAL			_			1
	or in all of	her extremities. On May 20, 200	<b>-</b>					
	The ALAN DIM Clien	4-#9'e V0081101191 9226221110111	·					
	I I - I - I Calain man	og one mas reviewed at the	.					
	residential facili	y. Reportedly, the assessment ordered. The assessment						
	had been court	lient #2's secretarial abilities had			,			
	l noncecod	Cancwering Telephone and	1					
4	the state of the s							
		TAINS STORICHICKE LEIGHTONS STOR						
		PARCALL OF INF COMPAGE:					•	1
	7 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 X 5 1 A 7 TO 2 TO 11 CHOOL #7 3 11 10 D 11 1 1 2						
	perform frustra	ted her. Although the client had rest in secretarial services, the	1				,	
	expressed inte	commended exploring the				•		
	The state of the	chaltared employingly						
		wish as common and bidoling recent	3 1					
	وتراكب الساسات	TO CATION TO LESIOUNING, STOP			,			
							t.	
1	The second of the second	A that Welder and Size of these						
	items be cons	idered based on her ability to	·					
	handle them.	1. A · 臺灣 · · · · · · · · · · · · · · · · ·					•	
	2 Δn inten/ie	w was conducted with the day		5 10				
	Z. Mighigan				Facility ID: 09G194		If continuation	sheet Page 4 of 2

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	4 4 4 5 <u>4 5 4 5</u>					
W 120	Continued From p	age 4 lient #2 on May 29, 2008 at	W	II S will meet with the	Day Program to	7/4/08
[조건 경기	I KO OO AM The ct	att nerson interviewed had		ensure programs and of	ojectives are	· \
111	Lworked with client	#2 for four months: According		appropriate and being i	mplemented.	
	to the staff client	#2 had objectives willow	1	appropriate	· · ·	
	- divided answerit	id the telephone, transletting				ļ
	Lealle and engagi	nd with the computer. The stan				1
2.9	indicated that clie	nt #2 could independently	e. )	· .		
	answer the telepr	none and could direct calls to the	it			
	appropriate static	of the time, to operate the		· .		· \
	#2 refused 100%	fused most times to answer and				· •
	computer and re	e calls. The staff described clie	nt			\
	transfer teleprior	s manipulative; shows off;				
	#Zs penavious a	ally and physically) when she di	d∖			1
	not have her way	y and projecting		4 4		1
		발생도 생활 5년 1월 22일 (1일 11일 12일 12일 12일 12일 12일 12일 12일 12일 1			0	
	During the obse	rvation at the day program on				
	May 20, 2008, a	t 10:30-AM. client #2 was asked	·			
	hy the surveyor.	to demonstrate what she would				
	cov when answe	aring the telephone at the day				
	baragram Client	出2 verbalized an appropriate		L. A.		
	arcoting and as	ked the allestions identified by t	ne			
1.	according to the	onding to calls: The Chells	1.	\ .		
	indicated verna	IV and hy destures that the day				
	program did no	Phave the correct type of phone		ILS will meet with th	e Day Program fo	r  7/4/08
	set that she nee	eded to perform the tasks. The		ILS will meet with the	adution for	77 <del>-1</del> 700
	staff agreed bu	f provided no resolution.		client #2 to provide a	Solution to	<b>,</b> [
		are a domanetrate for the		laurnorte to allow the	$\mathbf{m}$ to participate $\mathbf{z}$	1 .
	-Client#2 was v	villing to demonstrate for the officers. With	1	active treatment appr	opnately.	
	surveyor ner ar	t and hand over hand assistant	e,	\[ \]	0	
	the client was a	able to turn the computer on are	51			
	cometime Alth	iough staff needed to stabilize ii	(C)			
	bande /tremore	s) she pressed the correct keys	,			
	and used the c	omputer mouse. After perional	ng			
	the steps, the	client smiled.				
		The first of the second of the			0	
	NOTE: The ol	ient had a program to select an	a 🕴	19 - 🕆 💢 - 1.		1
T -	plav a game o	n the commuter, however, there	= '			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUI	RVEY
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		W 120			
W 120	Confinued From page 5	VV 123			
	was only one game available, Solitaire. Client #2 stated that she did not know how to play the		· , '		
	1-Colitoire	W 126	He H 维 · i		
W 126	483.420(a)(4) PROTECTION OF CLIENTS				
	RIGHTS				
	The facility must ensure the rights of all clients				
	Therefore the facility must allow individual clients		'		
	to manage their financial affairs and leading their		·	-	
2 1727	to do so to the extent of their capabilities.	,			
	This STANDARD is not met as evidenced by:				
	Pacad on clients (#1 #2) interviewed, the facility				
	selled to opering the rights of clients to be allowed	ı i	·		
	and encouraged to manage their thaticial attails				
1	and to be taught to do so to the extent of their				, 1
	capabilifies:				
	The findings include:				
	지계 문화하는 그 전에 있는데에 얼마나가 그 나는 그들이 되지 않는데 그 그 그 없는데 되었다.	5 <b>8</b>			j. l
	1. During the survey observations on May 28 ar	d	ILS has completed updates	for all	7/4/08
	29, 2008, client #1 held her wallet and verbalized that she had monies. The day program staff	_	: area esements and	1 WIII	
tip the great	atotad that the client enjoyed using the vending		· _1_mont appropriate act	ive treatmen	t
	machine of the day program and requially spon	e.	goals including but not lin	nited to mor	iey
	of purchasing nurses. The group numeration		management goals.		1
	- I I that the alread likes billises. On May 99,	as	management 8		1
	2008 at 10:45 AM the individual support plan was reviewed. The financial assessment was dated				1,
	May 5 2008 and reflected that Client#1 Was	1		•	
	temphic to perform in all areas assessed literature	ng			
	recognizing coins and counting. According to	,			·
	staff intentions conducted on May 29, 2000 at				
, see a see	5:10 PM, client #1 made store purchases with minimal assistance and consistently recognize	d			<i>÷</i> .
	10, 25, \$1.00, and \$5.00.				
	그렇면서 그 이 얼마는 눈이 이 뿐 때에 하는 그 이를 보고 있다.				
	There was no formal program written to			If continuation	sheet Page 6 of 23
1 '		100144	Facility ID: 09G194	II COMMINGATION .	<del>.</del>

STATEMENT	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER IDENTIFICA	DOT LEE TO THE PERSON OF THE P	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVE COMPLETED	,Υ
AND PLAN O		n w			05/30/20	008
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TAG	REGULATORY OR ESC IDENTITY THE			DELIGICITY		
W 126	Continued From page 6 encourage client #1 to engage in their greatest extent possible.		/ 126			
	2. Client #2 indicated during an conducted on May 30, 2008 at wanted to go to the bank and wanter was no evidence that the	4:10 PM, that sne ithdraw money. client had been				
	encouraged to learn or participal services. Client #2 did have a management program, althoug demonstrated knowledge of mo	ate in banking money hishe	vá Válto			
W 130	to participate in her finances.  483,420(a)(7) PROTECTION C RIGHTS  The facility must ensure the rig		W 130			
	Therefore, the facility must ensure treatment and care of persona	sure privacy during			٠. ا	
	This STANDARD is not met a Based on observation, the fac and ensure clients rights to primedication adminstration.	ility failed to teach	other staff wit	ide the nursing	staff and all lient's rights	7/4/08
	The findings include: On May 28 and 29, 2008 the	medication nurse	and their righ	to privacy.		,
	administered Client #1 and Clients and staff were seated observed to offer the clients a could not be determined that taught the right to privacy or the clients rights to privacy d	nearea where other The nurse was not a private area. It the clients had been that the staff ensure				·
W 13	pass 483 430 FACILITY STAFFIN	G	W 158			
	The facility must ensure that	specific facility	Facility ID: 09G194		continuation shee	t Page 7 of 2:

#### PRINTED: 06/19/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 05/30/2008 B. WING 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX TAG. W 158 Continued From page 7 W-158 ILS will provide extensive training to all staffing requirements are met. QMRPs on client's rights and active treatment to ensure that they have This CONDITION is not met as evidenced by. adequate knowledge of what is needed to Based on observations, client and staff support each client's needs. The new QA interviews, and record review, the facility failed to ensure that the Qualified Mental Retardation system in place will follow-up to ensure Professional demonstrated competency in that they have adequate knowledge and ensuring the protect of clients rights and staffing to support the client's needs. competency in ensuring all clients received active treatment services in accordance with their needs [Refer to W159]. The effects of these systemic practices results in the facility's failure to provide staffing to ensure active treatment supports. W 159 483.430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated coordinated and monitored by a ILS will meet with the Day Program to 7/4/08 qualified mental retardation professional ensure there is adequate staffing to comply with mealtime protocols for This STANDARD is not met as evidenced by: client #2. Based on observations, interviews with clients, staff, and the Qualified Mental Retardation Professional (QMRP), the QMRP failed to ensure that client's active treatment programs to include interventions were established, integrated, coordinated and monitored.

The findings include:

1. Interview with staff on May 30, 2008 at 10:30.
AM, client #2 "most times she doesn't drink with her lunch because the program will not allow her to always have soda." The day program staff stated how this would be a concern with other

NAME OF PROVIDER OR SUPPLIER  INNOVATIVE    STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  INNOVATIVE  STREET ADDRESS, CITY, STATE, ZIP CODE  114. DIVISION AVENUE, NE  WASHINGTON, DC 20019  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  W 159  Consumers desiring the same. According the collent #2's meal protocol, she was required to drink throughout her meals. During interview with the QMRP, he indicated that he had not been informed of any issues and was not made aware that client #2' was not drinking during her meals.  The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and	
INNOVATIVE  STREET ADDRESS, CITY, STATE, ZIP CODE 114. DIVISION AVENUE, NE WASHINGTON, DC 20019  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 159  Consumers desiring the same. According the client #2's meal protocol, she was required to drink throughout her meals. During interview with the QMRP, he indicated that he had not been informed of any issues and was not made aware that client #2' was not drinking during her meals.  2 The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and	30/2008
(X4) ID PREFIX TAG.    Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG.    W 159   Continued From page 8   Consumers desiring the same. According the client #2's meal protocol, she was required to drink throughout her meals. During interview with the QMRP, he indicated that he had not been informed of any issues and was not made aware that client #2 was not drinking during her meals.    2 The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and   programs   program criterions   program performance, program criterions, and   programs   program criterions   prog	
PREFIX TAG.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 159  Confinued From page 8  consumers desiring the same. According the client #2's meal protocol, she was required to drink throughout her meals. During interview with the QMRP, he indicated that he had not been informed of any issues and was not made aware that client #2 was not drinking during her meals.  2 The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and	(X5)
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that client #2 was not drinking during her meals.  2. The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and	7/4/08
2. The QMRP failed to ensure that there was congruency between client #1's assessments, program performance, program criterions, and	L
congruency between client #1's assessments, recommendations and programs program performance, program criterions, and	
staff implementation:	
According to client #1's Occupational Therapy assessment dated February 5, 2008 the client	
required minimal assistance in grooming, using deodorant, bathing, and caring for her hair. The assessment further reflected "continue to allow	
consumer to function as independently as possible when completing dressing and bathing activities."	
a. Client #1's individual program plan was	
reflected an objective that read "With physical assistance will participate in bathing herself on assistance will participate in bathing herself on 75% of the trials". Documentation for May 2008	
reflected 40% independence and March data reflected 100% physical assistance reflected 100% physical assistance clients' functional assessments.	7/4/0
Staff interviews were conducted on May 29, 2008  , between 2:00 PM and 4:00 PM. Both interviewees described client #1 as essentially interviewees.	
independent in areas of self help. It was stated that some assistance was needed. The staff who was interviewed indicated that client #1 was capable of holding a washcloth, washing her	
capable of holding a washcloth, washing to wash bath upper body, and making attempts to wash bath leg	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY LYO MULTIPLE CONSTRUCTION

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	3	COMPLET	ED.
		09G194	B. WING _	na <u>sa sa ngi</u> ta	05/30	/2008
NAME OF P	ROVIDER OR SUPPLIER		1.1	EET ADDRESS, CITY, STATE, ZIP CO 14 DIVISION AVENUE, NE VASHINGTON, DC 20019	DE	
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		
377.450	Cantinued From n	age 9	W 159			
W_159	b Client#1 had a included in her Inc.	toothbrushing program lividual Program Plan (IPP) direct care staff, the client		ILS will ensure that progrimplemented and develop	еиш	
	brush, but could be However, another	e putting toothpaste on the tooth rush her teeth independently. staff indicated that the client		accordance to the individual levels. The new Quality A forms developed will allo	Assurance	
	The program data	r hand assistance areflected that in May 2008		ionns developes		
	client #1 performs	ed the program independently although the objective was for				
	3 During the sur	vev from May 28 through May		ILS will ensure adequate Programs.	training on all	7/4/08
	below her stomad	1 wore a seat belt that hung th and loosely. On May 30, M a Physical Therapist note 1, 2008 was reviewed. The note		riograms.		
	revealed that clie wheelchair and v	nt#1 would unlock her an seat belts: Staff were a gait belt with the buckle behind	I.	ILS will ensure training protocols for all individ ensure that the Physical	uals. ILS WIII	7/4/08
	the seat. The P purchase a new seatbelt's releas	recommended that the facility custom wheelchair with the etab behind the seat. Although		evaluates client #1's ne Quality Assurance syste	eds. The new em will ensure	
	the interviews wi	ith the nurse and the Home cted May 30, 2008 at 3:15 PM, e client's behavior of unlocking		there is a follow-up wit recommendations.	h the	
	seatbelts did no evidence that th	t occur anymore, there was no e facility addressed the PT ns. Also, it could not be				
	determined that staff need for tra	the QMRP had addressed the aining and ensured the safety of				
	client#1. 4. The OMRP	failed to ensure that adaptive			٠.	
	equipment gear independent ab maintained for a	ed towards enhancing the littles were made operable and addressing the active treatment			•	
	needs of client:	#2 . [Refer to W436]		1.0	ic Liquation abo	et Page 10 d

STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF	
		09G194	B. WING	1	05/30	/2008
NAME OF P	ROVIDER OR SUPPLIER		1	EET ADDRESS, CITY, STATE, ZIP COD 14 DIVISION AVENUE, NE VASHINGTON, DC 20019		0.5
(X4) ID PREFIX TAG	/EXCHIDEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
3		<u> </u>				
W 159	were shared with that these assess	ed to ensure that assessments persons providing services and ment were used to meet client	W 159	gr (American September 1997)	-	
	#2's day program [Refer to W 120]  6. The QMRP fail	active treatment needs.		ILS has developed new active protocols to ensure that our actively involved in meaning and active treatment activities.	chemis are agful learning	7/4/08
	attempted to take dinner; however, the dish and plac noted, another clithe client's path tattempts to movin necessary space independently en	호루 (1) [편집[편집] 1 TTHE : 없는 보다는 것 같다.		ILS will ensure that all income the are encouraged to particindependent activities to income gross motor functioning.	cipate in	7/4/08
	May 29, 2008 at sweeping, setting simple laundry, program plan (IF program to set the meals; however.	the staff interview conducted on 5:40 PM, client #1 assisted with g the table, and performing According to client #1's individual PP), the client had a formal he dining room table prior to the participation that a clivity				
	c) Client #2 info interview that sh the boyfriend wa During the inter was pregenant records reflecte	iged on May 28 or 29, 2008.  Immed the surveyor during an ite had a boyfriend. A picture of as observed on her nightstand.  Jiew, client #2 mentioned that shand then laughed. Client #2's d a human sexuality assessment of need, there was no training	ì	ILS will have an updated assessment and will prov client #2 and any other cl	ide training it	7/4/08 or ed.

CENTER	S FOR MEDICARE & MEDICAID SERVICES	0.60 1411 7715	PLE CONSTRUCTION	(X3) DATE SUI	RVEY
STATEMENT AND PLAN OF	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		COMPLET	ED .
	09G194	B:WING		05/30	/2008
NAME OF PE	ROVIDER OR SUPPLIER	1: 1:	EET ADDRESS, CITY, STATE, ZIP CODE 14 DIVISION AVENUE, NE VASHINGTON, DC 20019		
			PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4):ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE APP DEFICIENCY)	JULD DE	COMPLÉTION DATE
er ger gêrkerd	<u> Parent III. B. Bardina                             </u>	-			
W 159	Continued From page 11 recommendations. It should be noted that the client admitted having a significant relationship that included kissing, dating and hugging.	W 159			
	d) It could not be determined the identified formal programs outlined in client #2's individual program plans were challenging to the client.				
	The IPP reflects a program implemented one times a month whereas client #2 "will send out mail to a preferred individual. She was to choose her kind of mail and indicate who the mail was going out to, shop for card, assist with addressing envelope; and drop the mail at a post	-			7/4/08
	office.  To date the documentation reflected that client		ILS has performed updated and will develop programs tappropriate for all individua	mar and	//4/08
	#2 had performed at 100% physical assistance. Each of the steps required for this program would require physical assistance as the client was limited in her physical abilities.	1			7.
	Will follow directive to independently read her residential information 5 times at 80% with verbal prompting. The task required that the staff	-			
	assists with writing the information or showing the addressed envelope.  The Occupational Therapy assessment reflecte				
	"consumer has severe coordination deficits resulting in the lack of smooth coordinated movement necessary for most fine motor tasks. It was also stated that the client "can hold a pen/pencil but writing is eligible due to coordination deficits"				
	During interview with client #2 on May 29, 2008 10:00 AM, the client stated her complete addres including the section of the city.	at ss		· · · ·	pet Page 12 of 23

### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION: A. BUILDING B. WING\_ 05/30/2008 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME: OF: PROVIDER OR: SUPPLIER 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE 1D SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID. TAG PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG W 195 483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. ILS will provide adequate training for all 7/4/08 staff on active treatment. This CONDITION is not met as evidenced by: Based observations, interviews, and record reviews the facility failed to provide continuous and aggressive active treatment services and interventions in accordance with recommendations presented by professional staff of the interdisciplinary team (IDT), [Refer toW196, W249], failed to provide opportunties for ILS has provided all individuals with 7/4/08 self-management [Refer to W247]; and failed to updated assessments to ensure provide adaptive equipment to enhance appropriate and adequate active independent skills. [Refer to W436]. treatment programs are implemented. The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure its clients were provided active treatment to address their identified needs. 483.440(a)(1) ACTIVE TREATMENT W 196 Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this support that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.

PRINTED: 06/19/2008 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1.,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
AND PLAN O	F CORRECTION	aben in toxion house.	A_BUILDING	<del>9</del> <u></u>		
		.09G194	B. WING		05/3	0/2008
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
i karpanja en 1990. Postanta en 1991.				14 DIVISION AVENUE, NE VASHINGTON, DC 20019		
INNOVA	HVE.		<u>. 1 1 2 2 </u>	PROVIDER'S PLAN OF CORRE		(X5)
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		DEFICIENCY)		<u> </u>
100 - 100 -	選続をきた。選ぶるをは、 Victory common to the Common to the		W 196	Control of the contro		
_W 196		age 13	VV 190			
	This STANDARD	is not met as evidenced by:			•	
	Based on observa	tions, interviews with client(s),		* * * * * * * * * * * * * * * * * * *		
Transport († 1864) Die State Bellen is	direct care staff, a	nd record verification, the				
	facility failed to ide	ntify and implemented day	3 <sup>4</sup>			
	program activities	that were related to client's(2)		_		
a 1700-1961-201 Waliota Kabupat		es to encourage an optimal				
	level of functioning			· · · · · · · · · · · · · · · · · · ·		·
				非常系统 多形 自己		
	The findings inclu	de				· I ·
				See W120		7/4/08
	Client #2's day pro	ogram failed to provide the client				
	with prevocationa	l opportunities as outlined in her				
ar di perdi. Ngjara	assessments. Als	so, the day program failed to				
	explore adaptive	equipment options that would				
	provide her furthe	r independent and possible job				
i in tall to a La Natalee la ale	security as evider	nced by the following:				
	1. Client #2 has	been diagnosed with severe				
	ataxia and preser	nted extreme uncontrollable				
,	tremors in all of h	ner extremities. On May 29, 2008				
	at 2:30 PM, clien	t#2's vocational assessment				
	dated February 2	6 2007 was reviewed at the				}
	residential facility	Reportedly, the assessment		. ∤		
	had been court o	rdered. The assessment	in	The state of the s	-	
	reflected that Clie	ent #2's secretarial abilities had				
	been assessed (	answering telephone and		See W120		7/4/08
	working on keybo	oard of a computer); however,		BEC 1120		
a Province de l'ori A Barack de Villa	due to the tremo	rs, she was "unable to perform				
	tasks such as us	ing a touchtone telephone and				
	manipulating key	board on the computer". This	For the second			
	assessment indi	cated that client #2's inability to				
	perform frustrate	d her. Although the client had			•	
A NEW Selection.	expressed intere	est in secretarial services, the				1
	assessment reco	ommended exploring the				
	possibility of a sl	neltered employment		1 PW15 -		
	environment su	ch as sorting and placing items				
	such as clothing	, groceries for restocking, small ns in the appropriate containers		·		
J. 1944 1.	toys or other iter	ns mane appropriate containers d that weight and size of these				
	III.was suggested				<del></del>	

STATEMENT	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SUF	
	09G194	B. WING	30 <u>11 Marie - 1</u>	05/30/	2008
NAME OF PI	ROMDER OR SUPPLIER	1	REET ADDRESS, CITY, STATE, ZIP CODE 14 DIVISION AVENUE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) . COMPLETION DATE
12 <b>.0</b> 4-1,0-13.0		<u> </u>			
W.196	Continued From page 14 Items be considered based on her ability to handle them.  2. An interview was conducted with the day program staff of client #2 on May 29, 2008 at	W 196			
	10:00 AM. The staff person interviewed had worked with client #2 for four months. According to the staff, client #2 had objectives which included answering the telephone, transferring calls, and engaging with the computer. The staff indicated that client #2 could independently		See W120		7/4/08
	answer the telephone and could direct calls to the appropriate stations. According to the staff, client #2 refused 100% of the time, to operate the computer and refused most times to answer and transfer telephone calls. The staff described clien				
	#2's behaviors as manipulative; shows off; aggressive (verbally and physically) when she did not have her way.  During the observation at the day program on				
	May 29, 2008, at 10:30 AM, client #2 was asked by the surveyor to demonstrate what she would say when answering the telephone at the day program. Client #2 verbalized an appropriate greeting and asked the questions identified by th program in responding to calls. The client		See W120		7/4/08
	indicated verbally and by gestures that the day program did not have the correct type of phone set that she needed to perform the tasks. The staff agreed but provided no resolution.				
	Client #2 was willing to demonstrate for the surveyor her ability in using the computer. With encouragement and hand over hand assistance the client was able to turn the computer on after sometime. Although staff needed to stabilize he hands (tremors), she pressed the correct keys		See W120		7/4/08
	and used the computer mouse. After performing	3			

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
	09G194	B WING	05/30/2008
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO 114 DIVISION AVENUE, NE WASHINGTON, DC 20019	DE
(X4) ID PREFIX TAG.	SUMMARY STATEMENT OF DEFICIENCIES (EACH-DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COL PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE
	Continued From page 15 the steps, the client smiled: NOTE: The client had a program to select and play a game on the commuter; however, there was only one game available, Solitaire. Client #2	W 196	7/4/08
	stated that she did not know how to play the Solitaire.  2. During this survey, client #2 presented with severe muscular movements that were uncontrollable. According the client's physical examination report dated November 19, 2007, the client suffers from Friedrich Ataxia and Olivoponocerbellar degenerative. The physical therapy assessment dated March 16, 2008	ILS will ensure that all recommendations are im	7/4/08 aplemented by Assurance for
	reference to several adaptive devices to assist the client. At the time of the survey, these device either had not been ordered, were not working, and not been implemented. [Refer to W436]  3. Client #2 informed the surveyor during an interview that she had a boyfriend. A picture of the boyfriend was observed on her nightstand. During the interview, client #2 mentioned that she was pregenant and then laughed. Client #2's	to track climical recomm	iendations.
W 24	records reflected a human sexuality assessment dated May 5, 2008. Although the assessment identified areas of need, there was no training recommended. It should be noted that the clier admitted having a significant relationship that included kissing, dating and hugging.	nt	7/4/08
	The individual program plan must include opportunities for client-choice and self-management.  This STANDARD is not met as evidenced by:	Facility ID: 09G194	If continuation sheet Page 16 of 2

STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		09G194	B. WING		05/30/	2008
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, NE WASHINGTON, DC 20019	<u>.</u>	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE
W.247	Based on observal review, the facility was provide the number of the three (Clients #2)  The findings inclusion of the findings inclusion of the three (Clients #2)  The findings inclusion of the findings including inclusion of the facility was provided including including inclusion of the facility was provided including including including inclusion of the facility was provided including inc	fion, staff interview, and record falled to ensure that each clien ecessay resources to as independently as possible, e clients in the sample.	ne	47		
	1. The PT asset "may benefit from wheel chair to en March 16 2008, benefit from a class noted Febru forms had been documentation of the recomme	ssment reflected that client #2- n using a laptray on her new neourage an upright position. Of the PT wrote that the client ma- ustom fitted manual wheelchair uary 28, 2008 that the required submitted. There was no furth available to determine the statu- nded devices. erated toothbush had been Staff interview was conducted	y It ier is	ILS was waiting for the equipment to be delivered exhausted all its options equipment was received obtained all adaptive equipment was received obtained all adaptive equipment was received obtained all adaptive equipment.	until the L. Client #2 ha	7/4/0 <u>8</u>
	4:30 PM on Ma revealed that st having an electr more tenure sta electric toothbri	y 29, 2008. This interview aff was not aware of client #2 in toothbrush. Another staff will sted that the consumer had an ush. The electric toothbrush was he clients personal kit; howeve because it did not have batteri	th as			

#### PRINTED: 06/19/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 05/30/2008 B. WING 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ΙĐ CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG W 247 Continued From page 17 W 247 There were no replacement batteries available in the facility. Additionally the staff did not know how to change the batteries, and the toothbrush head was worn and uncovered. 3. The Individual Support Plan (ISP), dated 7/4/08 ILS will ensure all staff is trained on all December 2007, identified that client #2's assistive devices included a mitt with a soap recommendations for individuals. pocket to assist bathing independently. During the environment inspection, there was no mitt observed. The QMRP could not explain why the was not available during survey. 4. On May 29, 2008 at 2:30 PM, client #2's vocational assessment dated February 26, 2007 was reviewed at the residential facility. Reportedly, the assessment had been court ordered. The assessment reflected that Client #2's secretarial abilities had been assessed 7/4/08 ILS will ensure that all individuals (answering telephone and working on keyboard of receive appropriate and recommended a computer); however, due to the tremors, she was "unable to perform tasks such as using a adaptive equipment. touchtone telephone and manipulating keyboard on the computer." This assessment indicated that client #2's inability to perform frustrated her. An interview was conducted with the day program staff of client #2 on May 29, 2008 at 10:00 AM. According to the staff, client #2 had objectives which included answering the telephone.

transferring calls, and engaging with the

answer and transfer telephone calls.

computer. The staff indicated that client #2 could independently answer the telephone and could direct calls to the appropriate stations. According to the staff, client #2 refused 100% of the time, to operate the computer and refused most times to

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SU COMPLET	RVEY TED		
		09G194	B WING 05/3				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1.14 DIVISION AVENUE, NE WASHINGTON, DC 20019	E	·		
(X4) ID PREFIX TAG	SUMMARY'S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD PE	(X5) COMPLETION DATE		
W 247	May 29, 2008, at	page 18 vation at the day program on 10:30 AM, client #2 was asked of demonstrate what she would ing the felephone at the day	W 247		, .		
W 249	program. Client greeting and ask program in respo- indicated verball program did not set that she need	#2 verbalized an appropriate ed the questions identified by the unding to calls. The client y and by gestures that the day have the correct type of phone ded to perform the tasks. The provided no resolution. ROGRAM IMPLEMENTATION	See W120		7/4/08		
	formulated a clie each client mus treatment progra interventions and and frequency to	nterdisciplinary team has ent's individual program plan, treceive a continuous active am consisting of needed discruices in sufficient number o support the achievement of the fied in the individual program.	l <b>e</b>				
	Based on obse and record revi	ID is not met as evidenced by wation, client and staff interview ew, the facility failed to ensure continuous opportunities to ningful learning activities for on the sample.	(nat		7/4/08		
	2008 at approx attempted to ta dinner; howeve the dish and p	clude:  rvation, conducted on May 28;  kmately 6.30 PM, client #1  ake her dish to the kitchen after  er, the QMRP intervene by takin  acing it in the kitchen. It should  client's wheelchair was blockir	ig				

STATEMENT	OF DEFICIENCIES F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G194	(X2) MULTII A. BUILDIN B. WING		(X3) DATE SU COMPLET	
NAME OF P	ROMDER OR SUPPLIER	- 14	REET ADDRESS, CITY, STATE, ZIP CODE 14 DIVISION AVENUE, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249 W 278	Confinued From page 19.  the client's path to the kitchen. There was no attempts to moving the sofa to allow the necessary space for client #1 to maneuveur and independently engage in the task.  2. According to the staff interview conducted on May 29, 2008 at 5:40 PM, client #1 assisted with sweeping, setting the table, and performing simple laundry. According to client #1's individual program plan (IPP), the client had a formal program to set the dining room table prior to meals, however, her participation in this activity was not encouraged on May 28 or 29, 2008.  483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR.	W 249	See W159		7/4/08
	Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematicall and demonstrated to be ineffective.  This STANDARD is not met as evidenced by Based on review of client #1's physician's orders and MAR, the facility failed to ensure that client's records documented that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and had demonstrated to be ineffective for client #1.  The finding includes	y ·			
	While reviewing client #1's physician's orders, of May 29, 2008 at 3:45 PM, it was reflected that the client had an one time order for Ativan 4 mg to use prior to an MRI of the brain. The MAR	ne Te			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION ... A, BUILDING 05/30/2008 B. WING. 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER. 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) PRÉFIX TAG W 278 Continued From page 20 W 278 ILS will ensure that all clients' rights are reflected that the dosage had been administered on the prescribed date, February 7, 2008. The respected and that staff will follow all approvals from the appropriate sources had been instructions included in the Behavior granted, however, there was no documented Support Plan. ILS will ensure that all evidence that alternatives of positive techniques other positive alternatives are had been considered. Interview with the LPN implemented. ILS will provide training Qualified Mental Retardation Professional, and Program Director on May 30, 2008 at 3:00 PM to nurses and QMRPs by a psychologist. confirmed that alternative techniques had not been implemented. 483.470(g)(2) SPACE AND EQUIPMENT W 436 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on client interview, observation, direct care staff interview, and record review, the facility failed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of recommended equipment 7/4/08 The findings include: See W196 During this survey, client #2 presented with severe muscular movements that were uncontrollable. According the client's physical examination report dated November 19, 2007, the client suffers from Friedrich Ataxia and Olivoponocerbellar - degenerative. The physical therapy assessment dated March 16, 2008. reference to several adaptive devices to assist

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### CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:: AND PLAN OF CORRECTION A. BUILDING B. WING 05/30/2008: 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE 1D SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID TAĠ PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG W 436 Continued From page 21 W 436 the client. These devices either had not been ordered, were not working, or had not been implemented at the time of this survey 1. The PT assessment reflected that client #2 "may benefit from using a laptray on her new 7/4/08 wheel chair to encourage an upright position. On See W247 March 16 2008, the PT wrote that the client may benefit from a custom fitted manual wheelchair. It was noted February 28, 2008 that the required forms had been submitted. There was no further documentation available to determine the status of the recommended devices. 2. The P.I assessment recommended that client #2 have a "plastic coated spoon to protect her teeth due to her tremors". The spoon was not available during this survey. According to the QMRP, there have been problems with the provider but the information had been requested. 3 A battery operated toothbush had been recommended. Staff interview was conducted at 4:30 PM on May 29, 2008. This interview revealed that staff was not aware of client #2 having an electric toothbrush. Another staff with more tenure stated that the consumer had an electric toothbrush. The electric toothbrush was retrieved from the clients personal kit; however, it was inoperable because it did not have batteries There were no replacement batteries available in the facility. Additionally the staff did not know how to change the batteries, and the toothbrush head was worn and uncovered. 4. The Individual Support Plan (ISP): dated December 2007, identified that one of client #2's assistive devices were hand weights. According to staff's interview on May 29, 2008 at 4.30 PM,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391

#### PRINTED: 06/19/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION-A. BUILDING 05/30/2008 B. WING 09G194 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 114 DIVISION AVENUE, NE WASHINGTON, DC 20019 INNOVATIVE PROVIDER'S PLAN OF CORRECTION COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4). ID: (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 436 Continued From page 22 W-436 the client complained that the weights were too heavy; and therefore, the previous QMRP ILS will have a Physical Therapist 7/4/08 instructed the staff not to use them. The consumer interjected during the interview with the reassess the appropriateness of hard staff that the weights were too heavy. There was weights to assist in feeding. no evidence that this information had been referred to the PT for review. It should be mentioned that the day program staff stated during interview conducted on May 29, 20087 at 10:00 AM that client #2 used hand weights during her meal and that the weights were functional in reducing her spillage. 5. The Individual Support Plan (ISP), dated December 2007, identified that client #2's See W247 assistive devices included a mitt with a soap pocket to assist bathing independently. During the environment inspection, there was no mitt observed. The QMRP could not explain why the mit was not available during survey.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		co	(X3) DATE SURVEY COMPLETED 05/30/2008	
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(X4) ID SUMMARY ST (EACH DEFICIENC PREFIX PEGULATORY OR	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETE DATE	
This receptification	NTS n survey was conducted from May 30 2008. At the time of the	1.000				
survey four femal resided in this gro diagnosed with m the remaining cli	es and two males clients bup home. One female was noderate mental retardation, an ents were diagnosed with mild in These clients had multiple			· W126	7/4/08	
clients were pres hospitalized prio remained in the was periodically wheelchair. The had physical cha	es. During this survey, five sent as one female had been root to the survey. One male client group home during the day and repositioned from his bed to his five clients that were observed allenges and required assistant nobilize within their environment ling of three clients was selected of this survey.	s ce		· • • • • • • • • • • • • • • • • • • •		
with clients, dire The findings we the group home review of recor investigations	survey were based on interview ect care staff, and medical staff ere also based on observations a and day program settings, and ds, including incident reports a	at d nd				
PROVISIONS Professional si and evaluation developmenta	ervices shall include both diagranching identification of levels and needs, treatment services designed to prevent in further loss of function by the	iosis			A	
Based on clie	s not met as evidenced by its (#1, #2) interviewed, the far re the rights of clients to be allo ed to manage their financial af	344CG			(X6) DATE	

If continuation sheet 1 of 9 7.IOV11 STATE FORM

ATEMENT ID PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING B. WING	ELE CONSTRUCTION	(X3) DATE SUI COMPLET 05/30	ED
AME OF P	ROVIDER OR SUPPLIER	414 DIVIS	DRESS, CITY, S ION AVENU TON, DC 20	TATE, ZIP CODE E, <b>NE</b> 0019		(XE)
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		(X5) COMPLETE DATE
L 401	and to be taught to capabilities.	do so to the extent of their	1.401			
	29, 2008, client.#/ that she had mon stated that the clie machine at the da of purchasing pur	vey observations on May 28 and held her wallet and verbalized es. The day program staff ent enjoyed using the vending by program and regularly spoke ses. The group home staff teat likes purses. On May 30,				
	2008 at 10:45 AM reviewed. The fir May 5, 2008 and unable to perform recognizing coins staff interviews c	Tthe individual support plantical reflected that client #1 was in all areas assessed including and counting. According to onducted on May 29, 2008 at 1 made store purchases with ce and consistently recognized.	3	See W126		7/4/08
	Thorewas no fo	rmal program written to :#1-to engage in her finances to	5			
	conducted on M wanted to go to There was no e encouraged to l services. Clien	cated during an interview ay 30, 2008 at 4:10 PM, that she bank and withdraw money vidence that the client had been earn or participate in banking #2 did have a money ogram, although she nowledge of money and a desiher finances.	re:			
	Fool CHMPP	FATION AND TRAINING shall provide habilitation and sidents to enable them to acqu	ire   420		· 	ntinuation sheet

STATEMEN AND PLAN (	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN B. WING		(X3) DATE SU COMPLET	
NAME OF P	114 DIVIS	ON AVENU	STATE, ZIP CODE JE, NE 0019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
420	Continued From page 2 and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.	1,420			V.E.
	This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provide the necessay resources to self-management as independently as possible, for one of the three clients in the sample.				
	(Clients #2)  The findings include:  During this survey client #2 presented with severe muscular movements that were uncontrollable. According the client's physical examination report dated November 19, 2007, the client suffers from Friedrich Ataxia and Olivoponocerbellar – degenerative. The physical				
	therapy assessment dated March 16, 2008 recommended several adaptive devices to assist the client with independency during activities of daily living		See W196		7/4/08
	1. The PT assessment reflected that client #2 may benefit from using a laptray on her new wheel chair to encourage an upright position. Or March 16.2008, the PT wrote that the client may benefit from a custom fitted manual wheelchair. It was noted February 28, 2008 that the required forms had been submitted. There was no furthe documentation available to determine the status of the recommended devices.				
	A battery operated toothbush had been recommended. Staff interview was conducted a 4:30 PM on May 29, 2008. This interview revealed that staff was not aware of client #2.	1			

Health Regulation Administration

STATEMEN AND PLAN C	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0203	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE SURV COMPLETE 05/30/2	D .
NAME OF P	ROMDER OR SUPPLIER STREET 11/4/D	TADDRESS, CITY, IVISION AVENU IINGTON, DC 2	JE, NE 0019	-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH-DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		(X5) COMPLETE DATE
L420	Continued From page 3 having an electric toothbrush: Another staff wit more tenure stated that the consumer had an electric toothbrush: The electric toothbrush was retrieved from the clients personal kit; howeve was inoperable because it did not have batteric. There were no replacement batteries available the facility. Additionally the staff did not know how to change the batteries, and the toothbrush head was worn and uncovered.  3. The Individual Support Plan (ISP). dated December 2007, identified that client #2's assistive devices included a mitt with a soap pocket to assist bathing independently. During the environment inspection, there was no mitt observed. The QMRP could not explain why mit was not available during survey.  4. On May 29, 2008 at 2:30 PM, client #2's vocational assessment dated February 26, 20 was reviewed at the residential facility. Reportedly, the assessment had been court ordered. The assessment reflected that Clier #2's secretarial abilities had been assessed (answering telephone and working on keybor of a computer), however, due to the tremors was "unable to perform tasks such as using touchtone telephone and manipulating keybor on the computer." This assessment indicate that client #2's inability to perform frustrated.  An interview was conducted with the day prostaff of client #2 on May 29, 2008 at 10:00 A According to the staff, client #2 had objective.	as r, it es in sh  the  007  ard she a bard ed her. bgram	See W247  See W120		7/4/08
	which included answering the telephone, transferring calls, and engaging with the computer. The staff indicated that client #2 independently answer the telephone and co direct calls to the appropriate stations. According	could uild			

Health Regulation Administration
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	OF DEFICIENCIES (X1): PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0203	A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 05/30/2008	
NAME OF PI	ROVIDER OR SUPPLIER STREET ADD	ORESS, CITY, ION AVENU TON, DC 2	0019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DOFD RE   COMER	ETE
1 420	Continued From page 4 to the staff, client #2 refused 100% of the time, to operate the computer and refused most times to answer and transfer telephone calls.	1 420			
	During the observation at the day program on May 29, 2008, at 10:30 AM, client #2 was asked by the surveyor to demonstrate what she would say when answering the telephone at the day program. Client #2 verbalized an appropriate greeting and asked the questions identified by the program in responding to calls. The client		See W120	7/4/	/08
1422	indicated verbally and by gestures that the day program did not have the correct type of phone set that she needed to perform the tasks. The staff agreed but provided no resolution.  3521.3 HABILITATION AND TRAINING	422			- 14
	Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident. 's Individual Habilitation Plan.				¥***
	This Statute is not met as evidenced by: Based on observation: client and staff interviews, and record review, the GHMRP failed to provide habilitation, training and assistance to residents i accordance with the residents Individual Habilitation Plan.		See W120	7/2	4/08
	Habilitation Plan.  The findings include:  Client #2's day program failed to provide the client with prevocational opportunities as outlined in her assessments. Also, the day program faile to explore adaptive equipment options that would provide her further independent and possible job security as evidenced by the following:	d l	Sec 11.20		13 (A)
	Client #2 has been diagnosed with severe ataxia and presented extreme uncontrollable				<u>.</u> <u> </u>

STATEMEN	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA- DECORRECTION IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SUR COMPLETE	
	HFD03-0203	B.WING_	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	05/30/	2008
NAME OF P	ROVIDER OR SUPPLIER STREET ADD	DRESS, CITY, ION AVENL ITON, DC 2	STATE, ZIP CODE JE, NE 0019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
1422	Continued From page 5 tremors in all of her extremities. On May 29, 2008 at 2 30 PM, client #2's vocational assessment	[ 422			
	dated February 26, 2007 was reviewed at the residential facility. Reportedly, the assessment had been court ordered. The assessment reflected that Client #2's secretarial abilities had		See W120		7/4/08
	been assessed (answering telephone and working on keyboard of a computer), however, due to the tremors, she was "unable to perform tasks such as using a touchtone telephone and "". This				
	manipulating keyboard on the computer "." This assessment indicated that client #2's inability to perform frustrated her. Although the client had expressed interest in secretarial services, the assessment recommended exploring the				
	possibility of a sheltered employment environment, such as sorting and placing items such as clothing, groceries for restocking, small toys or other items in the appropriate containers. If was suggested that weight and size of these items be considered based on her ability to				
	handle them.  2. An interview was conducted with the day program staff of client #2 on May 29, 2008 at 10:00 AM. The staff person interviewed had			,	100 m files 100 m files 100 m
	worked with client #2 for four months. According to the staff, client #2 had objectives which included answering the telephone, transferring calls, and engaging with the computer. The staff				
	indicated that client #2 could independently answer the telephone and could direct calls to the appropriate stations. According to the staff, client #2 refused 100% of the time, to operate the		See W120	:	7/4/08
	computer and refused most times to answer and transfer telephone calls. The staff described client #2's behaviors as manipulative, shows off, aggressive (verbally and physically) when she did				
	not have her way				72

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	TOF DEFICIENCIES DECORRECTION:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN B WING	付け、特別に対しては、アンド	(X3) DATE SU COMPLE 05/30	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, VISION AVENU INGTON, DC 2	STATE, ZIP CODE JE, NE		
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1422	During the observ	age 6 ation at the day program on 0:30 AM, client #2 was aske	422 			
	by the surveyor to say when answerit	demonstrate what she would be the telephone at the day werbalized an appropriate		See W120 •		7/4/08
	greeting and aske program in respon indicated verbally program did not hi set that she neede	d the questions identified by ding to calls. The client and by gestures that the day ave the correct type of phones to perform the tasks. The				
	Client #2 was willi surveyor her abilit encouragement a the client was able sometime. Althou	ovided no resolution.  Ing to demonstrate for the yin using the computer. With hand over hand assistance to turn the computer on after the computer of the correct keys.	ce; er ier			1 14
	nands (tremors); and used the con the steps, the clie	she pressed the correct keys iputer mouse. After performi nt smiled.	ng	See W120		7/4/08
	play a game on the	t had a program to select an he commuter, however, there he available, Solltaire. Clien d not know how to play the				
144		TATION AND TRAINING	1447			
	The habilitation a GHMRP shall include to, the	nd training of residents by th lude, when appropriate, but following areas:	e hot			
	(q) Human sexua	ality;				
	Based on client i	of met as evidenced by nterview, and record review, provide documented trainin area of	the g of			

Health Regulation Administration STATE FORM

STATEMEN AND PLAN	IT OF DEFICIENCIES: (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION :IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLET	red
	HFD03-0203		Hard Association (Inc.)	05/30	/2008
NAMEOF	PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		•
INNOVA	○報道等 ** 114 DIVIS	SION AVENU STON, DC 2	E.NE 0019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OUTD RE	(X5) COMPLETE DATE
ĸijĸijŖŶŶĸĸ		1447			, '
1 447	Continued From page 7				
	(q):Human sexuality:				
	The finding includes				
	During observation of and interview with client #2,			A. 44.65 4 4 4 4 4	
	she informed the surveyor that she does have a		사이탈 출시하다 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그		7/4/09
	boyfriend. She maintained a picture of the	(1) 10 10 10 10 10 10 10 10 10 10 10 10 10	See W159		7/4/08
	boyfriend on her nightstand. During the interview client #2 mentioned that she was pregenant and				
	then laughed Client #2's records reflected a				
	human sexuality assessment dated May 5, 2008.		하는 경우 중요 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그		,
	The assessment made no recommendations to				
	address issues that were identified as areas of				
	need. Also, there was no evidence of the client receiving training to assist her education since				
	she admitted to participating in have a significant			4	
	relationship, kissing, dating and hugging				
			(1) : 2022 (1) : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 :		A.
1.50	00 3523.1 RESIDENT'S RIGHTS	1500			
	- Courses - Jesterchall angura			11. 11. 11. 12. 12. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13	
	Each GHMRP residence director shall ensure that the rights of residents are observed and		계약기를 잃다는 것이 없는 것이 없다.		
	protected in accordance with D.C. Law 2-137, th	is			
	chapter, and other applicable District and federa				
	laws				, j
	This Statute is not met as evidenced by:				
	Based on observation, interview and record			•	
	review the Group Home for Persons with Menta				5/4/06
	Retardation (GHMRP) failed to observe and		See W120		7/4/08
	protect the rights of a resident, in accordance with federal regulation 42 CFR 483.		360 1122		,
	William and American				
	The findings include:			n S	
	1. Client #2's day program failed to provide the	2 <b>.</b> 1		•	
	client with prevocational opportunities as outline in her assessments. Also, the day program fail	ed			
경기 관련.	to explore adaptive equipment options that wou	ld	14. 14.2 No. 1		

Health Regulation Administration

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0203	(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  DRESS, CITY, STATE, ZIP CODE	05/30/2008
ME OF PROVIDER OR SUPPLIER		SION AVENUE, NE GTON DC 20019	
NOVATIVE  SUMMARY ST  X4) ID SUMMARY ST  PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION PREFIX CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) I SHOULD BE COMPLETE APPROPRIATE DATE
1500   Continued From F	page 8	1.500	
security. [See Fe 2. During the sur 30, 2008, client.#	rvey from May 28 through May  The wore a seat belt that hung  The word loosely On May 30;		· · · · · · · · · · · · · · · · · · ·
2008 at 10:45 Al dated February notation reflecte #1 would unlock	VI. a Thysical The 11 2008 was reviewed. The dient of that "staff reported that client her seat belt on the wheelchair the wore instructed to use a gall		7/4/08
belt with the bud follow up with n done and the no seatbelt with the According to in	ew custom wheelchair should be wheelchair should present the release tab behind the seat. terviews with the nurse and the	e ne	
PM, client #1.0 unsafe behavio	10es not currently distributed		
the safety of c	lient#1		

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